

Questionnaire No:

--	--	--	--	--	--	--	--	--

**YOU AND YOUR  
SURROUNDINGS**

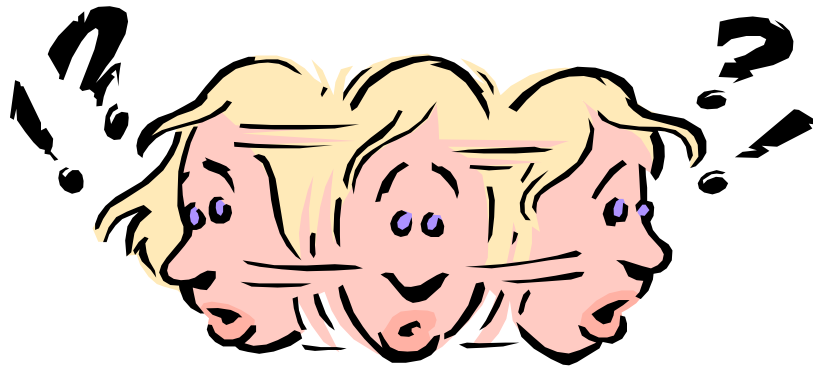
**This questionnaire is for the study child's mother or the person taking the role  
of mother**

**All answers are confidential**

<b>23/07/01</b>
-----------------

Please answer as much as you can.  
Just tick the box which is most accurate in your opinion.

There are no good or bad answers, just tell us what is true for you.  
If there is a question you don't want to answer or it  
doesn't apply to you – put a line through it.



We know there are some questions you have answered before but we need to  
ask them regularly so we can track the changes that  
have happened to you and your family. In time we will be able to tell whether  
the changes have had an effect on your health and that of your family.

We understand that this may be boring for you, but hope you will be patient.

THANK YOU FOR YOUR HELP

## **SECTION A: THINGS YOU DO**

A1. In the last 12 months, how often have you used any of the following, whether at work, at home or as a hobby:

		<b>Every day</b>	<b>Most days</b>	<b>About once a week</b>	<b>Less than once a week</b>	<b>Not at all</b>
a)	dental amalgam	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
b)	ceramics/enamels	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
c)	dry cleaning fluids	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
d)	electroplating	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
e)	glues	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
f)	leather working	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
g)	fabric/textiles	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
h)	dyes	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
i)	insecticides	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
j)	plastics	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
k)	metal cleaners/ degreasers, polishers	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
l)	petrol	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
m)	paint	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
n)	photographic chemicals	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
o)	electrical wiring	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
p)	machining	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
q)	soldering	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
r)	radiation(X-ray or other)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>

	Every day	Most days	About once a week	Less than once a week	Not at all
s) other chemicals (please tick and specify)	1	2	3	4	5

.....

.....

A2. In the last 12 months, how often have you done the following:

	Every day	Most days	About once a week	Less than once a week	Not at all
a) domestic work in other people's homes	1	2	3	4	5
b) hairdressing	1	2	3	4	5
c) farm work	1	2	3	4	5
d) hospital work	1	2	3	4	5
e) shift work	1	2	3	4	5
f) gardening	1	2	3	4	5

A3. What jobs have you had **since the study child was 5** that involved exposure to chemicals or machines? Include part-time and voluntary work. If you have not had a job that involved chemicals or machines write 'None'.

Job	Materials/chemicals/ machines used	Date started (month-year)	Date stopped (month-year)
1) .....	.....	.....	.....
.....	.....	.....	.....
2) .....	.....	.....	.....
.....	.....	.....	.....
3) .....	.....	.....	.....
.....	.....	.....	.....
<b>Job</b>	<b>Materials/chemicals/ machines used</b>	<b>Date</b>	<b>Date</b>

	machine used	started (month-year)	stopped (month-year)
4) .....	.....	.....	.....
.....	.....	.....	.....
5) .....	.....	.....	.....
.....	.....	.....	.....
6) .....	.....	.....	.....
.....	.....	.....	.....
7) .....	.....	.....	.....
.....	.....	.....	.....
8) .....	.....	.....	.....
.....	.....	.....	.....
9) .....	.....	.....	.....
.....	.....	.....	.....
10) .....	.....	.....	.....
.....	.....	.....	.....
11) .....	.....	.....	.....
.....	.....	.....	.....
12) .....	.....	.....	.....
.....	.....	.....	.....
13) .....	.....	.....	.....
.....	.....	.....	.....

If there is not enough space please continue on the back cover or on a separate sheet.

## **SECTION B: YOUR HOME**

Below are a number of questions about your home. They are similar to some you answered 3 years ago, and will be used to see how your circumstances might have changed.

		month	year						
B1.	a)	When did you move to your present address?	<table><tr><td></td><td></td></tr></table> <table><tr><td></td><td></td><td></td><td></td></tr></table>						
	b)	How many times have you moved home since your study child was 7 years old ?	<table><tr><td></td><td></td></tr></table>						

B2. Is your home:

being bought/mortgaged	<table><tr><td>0</td></tr></table>	0
0		
being bought from council	<table><tr><td>1</td></tr></table>	1
1		
owned - with no mortgage to pay	<table><tr><td>2</td></tr></table>	2
2		
rented from council	<table><tr><td>3</td></tr></table>	3
3		
rented from private landlord - furnished	<table><tr><td>4</td></tr></table>	4
4		
rented from private landlord - unfurnished	<table><tr><td>5</td></tr></table>	5
5		
rented from housing association	<table><tr><td>6</td></tr></table>	6
6		
other (please tick & describe)	<table><tr><td>7</td></tr></table>	7
7		

.....

B3. If you know your council tax band (A,B,C etc.) please write it here 

--

B4. Do you live in your own home or do you live with your parents or others?

live in own home	<table><tr><td>1</td></tr></table>	1
1		
live in partner's home	<table><tr><td>2</td></tr></table>	2
2		
live with your parents in their home	<table><tr><td>3</td></tr></table>	3
3		
live with your partner's parents in their home	<table><tr><td>4</td></tr></table>	4
4		
other situation (please tick & describe)	<table><tr><td>5</td></tr></table>	5
5		

.....

B5. Do you currently live in:

a whole detached house (or bungalow)	<div>1</div>
a whole semi-detached house/bungalow	<div>2</div>
an end of terrace house	<div>3</div>
a whole terraced house	<div>4</div>
a flat/maisonette (self contained)	<div>5</div>
room in someone else's house	<div>6</div>
other (please tick & describe)	<div>7</div>

.....

B6. What is the lowest level of your living accommodation:

basement	<div>78</div>
ground floor	<div>00</div>
1st floor	<div>01</div>
2nd floor or above, give floor.....	<div></div> <div></div>

B7. In the coldest time of year, describe the temperature in your:

	Very warm	Warm	About right	Cold	Very cold
a) living rooms	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b) the room where the study child sleeps	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

B8. Does your home have the following?

	Yes sole use	Yes shared with other household(s)	No ↓
a) kitchen where there is space to sit and eat	<div>1</div>	<div>2</div>	<div>3</div>
b) kitchen for cooking only	<div>1</div>	<div>2</div>	<div>3</div>
c) indoor flushing toilet	<div>1</div>	<div>2</div>	<div>3</div>

B9. Apart from the kitchen, how many rooms do you have for living and/or sleeping ?

B10. Do you have sole use of the following amenities or are they shared with other household(s)?

	Yes sole use	Yes shared	No, don't have at all
a) running hot water	<div>1</div>	<div>2</div>	<div>3</div>
b) bath	<div>1</div>	<div>2</div>	<div>3</div>
c) shower	<div>1</div>	<div>2</div>	<div>3</div>
d) garden or yard	<div>1</div>	<div>2</div>	<div>3</div>
e) balcony	<div>1</div>	<div>2</div>	<div>3</div>

B11. a) Is there a working telephone in your home (include mobiles)?

No	<div>1</div>	Yes, but for incoming calls only	<div>2</div>	Yes, a fully working phone or mobile phone	<div>3</div>
			<p><b>please go to B11b on page 9</b></p>		
			<p><b>If <u>yes</u>, go to B12a on page 9</b></p>		



**If no,**

B11. b) Where is the nearest working telephone that you can use in an emergency?

- |                                |                          |
|--------------------------------|--------------------------|
| pay phone in the building      | <input type="checkbox"/> |
| pay phone in the street        | <input type="checkbox"/> |
| neighbour's phone              | <input type="checkbox"/> |
| none within 5 minutes walk     | <input type="checkbox"/> |
| other (please tick & describe) | <input type="checkbox"/> |

.....

B12. a) Is there ever any damp, condensation or mould in your home?

Yes ☐ No ☐ → **If no, go to B13a on page 10**

**If yes,**

b) How much of a problem is damp or condensation?

- |                         |                          |
|-------------------------|--------------------------|
| no damp or condensation | <input type="checkbox"/> |
| not serious             | <input type="checkbox"/> |
| fairly serious          | <input type="checkbox"/> |
| very serious            | <input type="checkbox"/> |

c) How much of a problem is mould?

- |                |                          |
|----------------|--------------------------|
| no mould       | <input type="checkbox"/> |
| not serious    | <input type="checkbox"/> |
| fairly serious | <input type="checkbox"/> |
| very serious   | <input type="checkbox"/> |

B13. a) Does your roof leak at all? (If you have another flat above yours, please tick

‘does not apply’)

does not apply

no leak

yes, slight leak

yes, serious leak

b) In wet weather, does water get in from anywhere else, such as through badly fitting windows or doors?

no leaks

yes, slight leaks

yes, serious leaks

B14. Taking everything into account, which of the following best describes your feeling about your home?

satisfied

fairly satisfied

dissatisfied

very dissatisfied

B15. In the past year have you done any of the following:

**Yes, in  
own home**

**Yes,  
elsewhere**

**Yes, both  
home and  
elsewhere**

**No, not  
at all**

a) sanded floors

b) stripped wallpaper

c) removed paint or varnish

B16. **In the past year** have any of the following rooms been decorated or had any brand new furniture?

a) <b>Your bedroom:</b>	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
i)     painted	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
ii)    wallpapered	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
iii) <u>new</u> carpet	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
iv) <u>new</u> furniture	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
b) <b>Your living room:</b>			
i)     painted	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
ii)    wallpapered	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
iii) <u>new</u> carpet	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
iv) <u>new</u> furniture	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
c) <b>The room the study child sleeps in:</b>			
i)     painted	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
ii)    wallpapered	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
iii) <u>new</u> carpet	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
iv) <u>new</u> furniture	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
d) <b>Any other rooms:</b>			
i)     painted	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
ii)    wallpapered	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
iii) <u>new</u> carpet	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
iv) <u>new</u> furniture	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	9 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>

which room (s)?.....

B17. How would you rate **your home** in relation to that of other homes with children?

a)	much cleaner	<input type="text" value="1"/>
	a bit cleaner	<input type="text" value="2"/>
	about the same	<input type="text" value="3"/>
	less clean	<input type="text" value="4"/>
	much less clean	<input type="text" value="5"/>
	don't know	<input type="text" value="9"/>

b)	much tidier	<input type="text" value="1"/>
	a bit tidier	<input type="text" value="2"/>
	about the same	<input type="text" value="3"/>
	less tidy	<input type="text" value="4"/>
	much less tidy	<input type="text" value="5"/>
	don't know	<input type="text" value="9"/>

B18. Here is a list of some things that can be a problem in people's homes or in the neighbourhood. How much of a problem are the following for you and your family:

		<b>Serious problem</b>	<b>Minor problem</b>	<b>Not a problem</b>	<b>No opinion</b>
a)	Badly fitted doors and windows	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
b)	Poor ventilation	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
c)	Noise travelling between the rooms of your home	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
d)	Noise from other homes	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
e)	Noise from outside in the street	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
f)	Rubbish or litter dumped around your neighbourhood	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
g)	Dog dirt on pavement/walkways	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
h)	Worry about vandalism	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
i)	Worry about burglaries	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
j)	Worry about muggings or attacks	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
k)	Disturbance from teenagers or youths	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
l)	Other problems (please tick & describe)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>

.....

.....

B19. a) Do the other people in your neighbourhood:

		<b>No, never</b>	<b>Rarely</b>	<b>Some- times</b>	<b>Often</b>	<b>Always</b>
i)	visit your home	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii)	argue with you	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii)	look after your children	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iv)	keep to themselves	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

b) Do you:

		<b>No, never</b>	<b>Rarely</b>	<b>Some- times</b>	<b>Often</b>	<b>Always</b>
i)	visit the home of your neighbours	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii)	argue with your neighbours	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii)	look after your neighbour's children	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iv)	keep to yourself	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

B20. What do you think of your neighbourhood as a place to live?

a very good place to live	<div>1</div>
a fairly good place to live	<div>2</div>
not a very good place to live	<div>3</div>
not at all a good place to live	<div>4</div>

B21. How heavy is the traffic on the street where you live?

very heavy	<input type="checkbox"/>
quite heavy	<input type="checkbox"/>
not very heavy	<input type="checkbox"/>
hardly any traffic	<input type="checkbox"/>

B22. To heat your home in winter what methods do you mainly use?  
(Please tick all boxes that apply)

	(i) In main living room	(ii) In study child's bedroom	(iii) In other rooms
a) central heating or storage heaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) wood stoves or wood fires	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) coal fires	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) paraffin heaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) gas fires (mains gas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) gas fires (bottled gas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) other type of heating (please tick & describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....			
h) no heating in this room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B23. If your home is centrally heated in winter, please describe:

a) type:

solid fuel	<input type="checkbox"/>	no central heating	<input type="checkbox"/>	→ <b>Go to B24 below</b>
oil	<input type="checkbox"/>			
gas	<input type="checkbox"/>			
electricity	<input type="checkbox"/>			
other (please tick & describe)	<input type="checkbox"/>	.....		

b) How is heating distributed?

Radiators	<input type="checkbox"/>	warm air	<input type="checkbox"/>	storage heaters	<input type="checkbox"/>
under floor heating	<input type="checkbox"/>	other	<input type="checkbox"/>	please describe .....	

c) Where is the boiler?

kitchen	<input type="checkbox"/>	living room	<input type="checkbox"/>	no boiler	<input type="checkbox"/>
other (please tick & describe)	<input type="checkbox"/>	.....			

B24. a) Do you use gas for cooking?

Yes, ring(s) only	<input type="checkbox"/>
yes, oven only	<input type="checkbox"/>
yes, rings and oven	<input type="checkbox"/>
no, not at all	<input type="checkbox"/>



- b) Do you use the cooker (whether gas or electric) for any other purpose than cooking (e.g. drying clothes, heating the room)?

Yes  No  Don't have a cooker  → go to B25 below

If **yes**, please describe: .....

- c) How old is your cooker?

more than 20 years	<input type="text" value="1"/>
10-19 years old	<input type="text" value="2"/>
5-9 years old	<input type="text" value="3"/>
2-4 years old	<input type="text" value="4"/>
less than 2 years old	<input type="text" value="5"/>
don't know	<input type="text" value="6"/>

- d) When you first got your present cooker – was it:

brand new  second hand

- B25. When someone is cooking, how often do they get rid of the smells and steam in the kitchen using the following:

	Usually	Sometimes	Not at all	Never cook
a) open windows	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="7"/>
b) ventaxia/air extractor	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	↓ <b>Go to B26 on page 18</b>
c) extractor hood which vents to outside	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	
d) extractor hood that doesn't vent to outside	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	
e) other (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	

.....

- B26. How often do you have any windows open in your home:

		Windows almost always open ↓	Windows open only when weather is good	Windows open occasionally ↓	Windows almost never open
a) <b>In <u>summer</u>:</b>					
i) day	1	2	3	4	
ii) night	1	2	3	4	
b) <b>In <u>winter</u>:</b>					
i) day	1	2	3	4	
ii) night	1	2	3	4	

c) Are any of your windows double glazed? (including secondary double glazing)

yes, all of them	1	yes, some of them	2
no, none of them	3	don't know	9

d) Does your home have chimneys?

Yes	1	No	2
-----	---	----	---

e) **If yes,** have they been blocked up?

yes, all of them	1	yes, some of them	2
no	3	don't know	9

B27. Do you use a thermometer or thermostat to help keep the temperature at the level you want in winter?

a) In main living room:

thermostat on radiators	1	room thermostat	2	room thermometer	3
none of these	4	other	5	(please describe) .....	

b) In your study/child's bedroom:

1	2	3
---	---	---

thermostat on  
radiators

room thermostat

room thermometer

none of these

other

(please describe) .....

c) What temperature do you try to maintain in winter? (If you don't try to maintain any particular temperature put 97)

(i) in living rooms

day

night

(ii) in room where your  
study child sleeps

day

night

B28. a) This question is about whether various appliances in your home were fitted by professionals or by you, your family or friends.

**Fitted by professionals**

	<b>Yes</b>	<b>No</b>	<b>Don't know</b>	<b>Don't have this</b>
(i) central heating boiler	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="7"/>
(ii) gas fires	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="7"/>
(iii) cooker	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="7"/>

b) Do you have these appliances regularly serviced?

	<b>Regularly serviced</b>	<b>Serviced occasionally</b>	<b>Not serviced</b>	<b>Don't have this</b>
(i) central heating boiler	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="7"/>
(ii) gas fires	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="7"/>
(iii) cooker	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="7"/>

B29. Do you have a tumble dryer?

yes, gas

yes, electric

no, don't have

B30. a) How often do you drive a car, van or lorry ?

almost  
every  
day

2-5  
times   
a week

once a  
week

rarely

never

→ **Go to Section C on page 21**

b) What type of fuel is used?

diesel

lead free  
petrol

other  
petrol

## **SECTION C: YOUR HOUSEHOLD**

C1. a) How many people live in your household now? (including yourself)

- i)  adults (over 18 years)
- ii)  young adults (16-18 years)
- iii)  children (less than 16 years)

b) Please indicate who the adults over 18 are:

- |   | Yes                  |
|---|----------------------|
| i) yourself                                   | <input type="text"/> |
| ii) your husband/partner                      | <input type="text"/> |
| iii) your parent(s)                           | <input type="text"/> |
| iv) your husband's/partner's parent(s)        | <input type="text"/> |
| v) other relation(s) of yourself              | <input type="text"/> |
| vi) other relation(s) of your husband/partner | <input type="text"/> |
| vii) friend(s)                                | <input type="text"/> |
| viii) lodger                                  | <input type="text"/> |
| ix) other (please tick and describe)          | <input type="text"/> |

.....

C2. a) Do you have a rule that smoking never happens in particular rooms?

- no smoking in house at all
- smoking only allowed in some rooms
- smoking allowed anywhere

b) How many people living in your household (including yourself) are smokers?

C3. a) What is your present marital status?

never married	<input type="text" value="1"/>
widowed	<input type="text" value="2"/>
divorced	<input type="text" value="3"/>
separated	<input type="text" value="4"/>
married (once only)	<input type="text" value="5"/>
married for second or third time	<input type="text" value="6"/>

b) If married, what was the date of the most recent marriage?

day	month	year
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

C4. a) Does the biological (natural) father of the 8 year old study child live with the study child?

No  Yes   **If yes, go to C4c on page 23**

**If no,**

b) i) How old was the child when the natural father stopped living with the child?


months

(put 00 if the father never lived with the child)

ii) How often does the natural father see the study child?

not at all	<input type="text" value="1"/>
less than once a month	<input type="text" value="2"/>
about once a month	<input type="text" value="3"/>
about once a fortnight	<input type="text" value="4"/>
once or twice a week	<input type="text" value="5"/>
nearly every day	<input type="text" value="6"/>

child's father is dead

 **Go to C4c on page 23**

C4. b) iii) Does he help support the child financially?

yes, on a regular basis

yes, occasionally

no

c) Does the biological (natural) mother of the 8 year old study child live with the study child?

No

Yes



If yes, go to C5 on page 24

If no,

i) How old was the child when the natural mother stopped living with the child?

months

(put 00 for from birth)

ii) How often does the natural mother see the study child?

not at all

less than once a month

about once a month

about once a fortnight

once or twice a week

nearly every day

child's mother  
is dead



Go to C5  
on page 24

iii) Does she help support the child financially ?

yes, on a regular basis

yes, occasionally

no

To make the questions less complicated, for the rest of this section, for **partner** we mean **husband or partner**.

C5. Please indicate how many of the children living in your household have:

**Number of children**

- |    |   |                      |                      |
|----|---|----------------------|----------------------|
| a) | you and your partner as their natural parents   | <input type="text"/> | <input type="text"/> |
| b) | their natural mother present (but their natural father is not present)                      | <input type="text"/> | <input type="text"/> |
| c) | the natural father present (but not their natural mother)                                   | <input type="text"/> | <input type="text"/> |
| d) | neither natural parent present<br>(please describe whether you have adopted, fostered etc.) | <input type="text"/> | <input type="text"/> |

.....

C6. Are there other children of yourself or your partner who visit (whether to play or to stay)?

- |  | No                        | Yes                       | Number of children                             |
|--|---------------------------|---------------------------|--|
| a) Children of my partner but not me     | <input type="text"/><br>1 | <input type="text"/><br>2 | <input type="text"/><br>→ <input type="text"/> |
| b) Children of myself but not my partner | <input type="text"/><br>1 | <input type="text"/><br>2 | <input type="text"/><br>→ <input type="text"/> |
| c) Children of me and my partner         | <input type="text"/><br>1 | <input type="text"/><br>2 | <input type="text"/><br>→ <input type="text"/> |

C7. Do any of the people living in your household, including yourself and your study child, have a chronic illness or disabling condition (for example asthma, arthritis, epilepsy, depression)

Yes   
1      No   
2 → **If no, go to C8 on page 25**

**If yes**, please describe:

**Nature of condition(s)**

**Person(s) involved**

(state relationship to you - husband/  
partner, child, mother, etc.)

.....  
.....  
.....  
.....

.....  
.....  
.....  
.....



C8. a) Do you have any pets in the household?

Yes  No  → If **no**, go to C9 below

If **yes**,

b) How many of the following pets do you have?

	Number
i) cats	<input type="text"/> <input type="text"/>
ii) dogs	<input type="text"/> <input type="text"/>
iii) rabbits	<input type="text"/> <input type="text"/>
iv) rodents (mice, hamster, gerbil etc.)	<input type="text"/> <input type="text"/>
v) birds (budgerigar, parrot, etc.)	<input type="text"/> <input type="text"/>
vi) fish	<input type="text"/> <input type="text"/>
vii) turtles/tortoises/terrapins	<input type="text"/> <input type="text"/>
viii) other pets (please say how many and describe)	<input type="text"/> <input type="text"/> .....

C9. **The other children in the household:**

How many brothers and sisters does your 10 year old study child have that **live with you or visit at least 1 day a week?** (include half-brothers and half sisters, step-brothers and step-sisters, fostered or adopted children.)

	Brothers	Sisters
a) younger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
b) same age (e.g. twin of the study child)	<input type="text"/>	<input type="text"/>
c) older	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

C10. How would you describe the noise level in your home?

	<b>Yes</b>	<b>No</b>
a) there is usually music or television on in our home	<div>1<input type="checkbox"/></div>	<div>2<input type="checkbox"/></div>
b) the noises from outside our home are disturbing (neighbours, traffic, factory)	<div>1<input type="checkbox"/></div>	<div>2<input type="checkbox"/></div>
c) it is often so noisy at home it is difficult to hold a conversation	<div>1<input type="checkbox"/></div>	<div>2<input type="checkbox"/></div>

## **SECTION D: PILLS AND POTIONS**

D1. Please indicate below if you have used any **medicines** (pills, syrups, inhalers, drops, sprays, suppositories, pessaries, ointments etc including homeopathic and herbal remedies) in the last 12 months.

Please include medicines prescribed by your doctor and also those you may have purchased over the counter. (**Do not include vitamins and supplements** unless taken for a specific medical condition, as these are covered in the next section).

If possible give the full name of the medicine and indicate how often it was used. If you need more lines for a particular category please include the additional medicines under the 'Other conditions' section at the end of this question on page 30.

Medicine, pills, drops, ointment etc for:	Yes in past 12 months	If yes, give name of substance	How often did you take/use this?			
			Every day	Most days	Some times	Once or twice
a) Headache or or migraine	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Backache	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Period pain	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Other pain	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Indigestion	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Nausea	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often did you take/use this?

Medicine, pills, drops, ointment etc for:	Yes in past 12 months	If yes, give name of substance	Every day	Most days	Some times	Once or twice
g) Vomiting	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h) Diarrhoea	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i) Piles or haemorrhoids	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
j) Constipation	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
k) Depression	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
l) Anxiety or nerves	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
m) Sleeping	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
n) Psoriasis	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
o) Eczema	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

How often did you take this?

Medicine, pills, Yes in If yes, give

drops, ointment etc for:	past 12 months	name of substance	Every day	Most days	Some times	Once or twice
p) Asthma	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
q) Hay fever	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
r) Other allergies	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
s) Sore throat	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
t) Cough	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
u) A cold	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
v) Flu	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
w) Other infection	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

Medicine, pills, drops, ointment etc for:	Yes in past 12 months	If yes, give name of substance	How often did you take/use this?			
			Every day	Most days	Some times	Once or twice
x) Thrush	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y) Cystitis	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z) Diabetes	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
za) Epilepsy	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zb) High blood pressure	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zc) Oral contraceptive	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zd) HRT (hormone replacement therapy)	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ze) Other condition (please tick & describe)	<input type="checkbox"/>	.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zf) Other condition (please tick & describe)	<input type="checkbox"/>	.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medicine, pills, drops, or ointment etc for:	Yes in past 12 months	If yes, give name of substance	How often did you take/use this?			
			Every day	Most days	Some times	Once or twice
zg) Other condition (please tick & describe)	<input type="checkbox"/>	.....→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zh) Other condition (please tick & describe)	<input type="checkbox"/>	.....→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zi) Took/used no medicines, pills, drops or ointment	<input type="checkbox"/>					

D2. Vitamin, mineral and other supplements are widely used. Some people take them regularly for their health, whereas others may use them more sporadically to try to improve a specific area of their health. Please indicate below whether you have used such supplements regularly, occasionally or not at all **in the last 12 months**.

		Used in last 12 months		
		Regularly	Occasionally	Not at all
a)	Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b)	Minerals (e.g. calcium, iron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c)	Oil supplements e.g. fish oils, evening primrose oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d)	Other supplements e.g. Ginseng	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D3. Please describe below any vitamins, minerals such as iron or calcium or other supplements taken for your health in the **past month** and indicate how often you used them.

	Every day	Most days	About 1-2 times a week	Less than once a week	Not at all
a) <b>Vitamins</b> (Please say which vitamins and give brand name)					
i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Every day	Most days	About 1-2 times a week	Less than once a week	Not at all
--	--------------	--------------	------------------------------	--------------------------------	---------------

**b) Mineral supplements**

(Please say which minerals e.g. iron, calcium, and give brand name)

i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

**c) Oil supplements**

(Please say which, e.g. fish oils, Evening Primrose oil, and give brand name)

i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

**d) Other supplements**

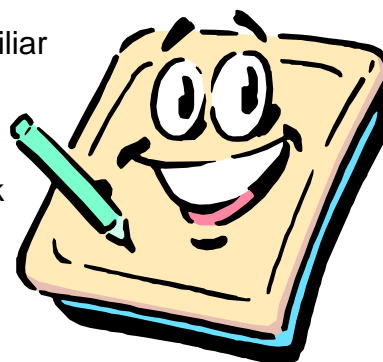
(Please say which, e.g. Ginseng, Royal Jelly, and give brand name)

i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>



Some of these questions may seem familiar

Please bear with us– but we need to ask them again



## **SECTION E: YOUR OCCUPATION AND LIFESTYLE**

E1. a) Since the study child was 5 years old have you worked at all? (please tick all that apply).

- |                                  |                          |  |
|----------------------------------|--------------------------|--|
| no, not at all                   | <input type="checkbox"/> | → If <b><u>no</u></b> , go to Question E8 on page 38 |
| (i) yes, paid work at home       | <input type="checkbox"/> |  |
| (ii) yes, paid work outside home | <input type="checkbox"/> |  |
| (iii) yes, voluntary work        | <input type="checkbox"/> |  |

b) Have you been working all the time since you started work after the study child was 5?

- |                                  |                          |  |
|----------------------------------|--------------------------|--|
| yes, same job all the time       | <input type="checkbox"/> | → Now go to (iii) below                      |
| yes, but not always the same job | <input type="checkbox"/> |  |
| no, stopped & started again      | <input type="checkbox"/> | no, do not work now <input type="checkbox"/> |
- 
- |                            |                      |                      |  |
|----------------------------|----------------------|----------------------|--|
|                            | <b>month</b>         | <b>year</b>          |  |
| i) when did you last stop? | <input type="text"/> | <input type="text"/> | → If do not work now go to E7 on page 38 |
- 
- |                               |                      |                      |
|-------------------------------|----------------------|----------------------|
|                               | <b>month</b>         | <b>year</b>          |
| ii) when did you start again? | <input type="text"/> | <input type="text"/> |
- 
- |                                       |                      |
|---------------------------------------|----------------------|
| iii) how many jobs are you now doing? | <input type="text"/> |
|---------------------------------------|----------------------|
- iv) Whether or not you are self-employed, what job(s) are you doing? (please describe the job(s) you do and the type of industry/employer(s) you work for). If you are self-

employed please also say so.

.....  
.....

c) How many hours did you work last week ?   hours

(i) Was this a typical week?

Yes   No, usually work more hours   No, usually work less hours

**If no,**

(ii) how many hours in a usual week?   hours

d) Does your work include weekends?

Yes, usually   Yes, sometimes   No, never

e) Do you work in the evenings or at night?

Yes, often   Yes, sometimes   No

f) How would you describe the physical effort you need for your current job(s)?

very little effort, mostly sitting    
some physical effort    
quite a lot of physical effort    
considerable physical effort

g) Do you usually work:

the basic no. of hours per week

basic hours plus paid overtime

longer than basic hours (but not paid extra)

self-employed - as long as necessary

h) Which of the following best describes how you are paid in your present job?

Monthly salary  
plus performance

Monthly salary  
only

Weekly  
wage

Hourly paid

Piecework

Self-employed

Other (please  
describe)

.....

i) Are you on a recognised pay scale with increments, either automatic or performance related?

Yes

No

Don't know

j) If you decided to leave your job, how much notice are you officially required to give?

Less than  
one week

1, 2 or  
3 weeks

1 or 2  
months

3 months  
or more

not relevant  
(self-employed)

Don't know

k) In your sort of work, are there opportunities for promotion either in your current organisation or by changing employers?

Yes

No

Don't know

l) Who decides what time you start and leave work?

Flexitime system  Employer decides

I decide, within certain limits  Negotiated with employer

m) Does your job require you to design and plan important aspects of your own work, or is your work largely specified for you?

I am required to design/plan my work  Work is largely specified by others  Other

n) How much influence do you personally have in deciding what tasks you are to do?

A great deal  A fair amount

Not much  None

E2. What are the main reasons you work? (tick all that apply)

**Yes**

- |   |                                |
|---|--------------------------------|
| a) financial, I am important as a breadwinner | <input type="text" value="1"/> |
| b) financial, for family extras               | <input type="text" value="1"/> |
| c) career                                     | <input type="text" value="1"/> |
| d) enjoyment                                  | <input type="text" value="1"/> |
| e) to get out of the home                     | <input type="text" value="1"/> |
| f) other (please tick & describe)             | <input type="text" value="1"/> |

.....

E3. Are you working at the same status as you did before the study child was born?

didn't work before

no, lower level

yes, same level

no, higher level

E4. Do you find your job satisfying?

Yes

No

Sometimes

E5. Do you wish that you could generally spend more time with your study child?

yes, often

yes, sometimes

yes, but rarely

no, not at all

E6. a) How do you usually travel to work? (Tick all that apply)

**Yes**

**Work at home**

i) public transport (bus, train)

→ Go to E7 on page 38

ii) car

iii) cycle

iv) walk

v) other

(please tick and describe)

.....

b) How long does it usually take:

	Less than 15 mins	15-29 mins	30-59 mins	An hour or more
i) to travel to work	<div><div>1</div></div>	<div><div>2</div></div>	<div><div>3</div></div>	<div><div>4</div></div>
ii) to travel home from work	<div><div>1</div></div>	<div><div>2</div></div>	<div><div>3</div></div>	<div><div>4</div></div>

E7. Please list all jobs you have had since your study child's 7th birthday, apart from your present job if you are currently working.

Age of child at start of job	Job	Hours worked in usual week
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

**If you are working now please go to Question E9 on page 39**

**If you are not working now:**

E8. Have you chosen not to work so that you can stay at home with your children?

No 

1

 Yes 

2

 → **If yes, go to E9 on page 39**

**If no,**

a) Have you been looking for work? Yes 

1

 No 

2

 → **If no, go to E8c on page 39**

**If yes**

b) How long have you been seeking work?  months → **now go to E9 on page 39**

E8. c) If you have not been looking for work, please give reasons (tick all that apply):

- |                           |                          |                                    |                          |
|---------------------------|--------------------------|------------------------------------|--------------------------|
| (i) do not want to work   | <input type="checkbox"/> | (iv) not well enough               | <input type="checkbox"/> |
| (ii) looking after family | <input type="checkbox"/> | (v) other (please tick & describe) | <input type="checkbox"/> |
| (iii) on maternity leave  | <input type="checkbox"/> | .....                              |                          |

E9. In the past 2 years have you taken any courses or educational training?

- |                                   | Yes                      | No                       |
|-----------------------------------|--------------------------|--------------------------|
| a) training within my job         | <input type="checkbox"/> | <input type="checkbox"/> |
| b) evening classes                | <input type="checkbox"/> | <input type="checkbox"/> |
| c) university course              | <input type="checkbox"/> | <input type="checkbox"/> |
| d) other (please tick & describe) | <input type="checkbox"/> | <input type="checkbox"/> |

.....

E10. What is your job like? (If you are no longer working answer for your most recent job)

- |  | Yes,<br>always           | Yes,<br>mostly           | Some-<br>times           | Not<br>very<br>often     | Never<br>↓               |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Do you enjoy your job?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Do you have problems at work?           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are the people at your work friendly?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Are the people at your work supportive? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Is it very noisy?                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Do you work in a smoky atm              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Although we asked a lot about you when you were pregnant, now that we are looking at the ears and hearing of all the study children, we find there are some questions we need to ask.

**Please think back to the time when you were pregnant with your 10 year old study child**


☐

## **SECTION F: NOISE DURING PREGNANCY**

### **Noise at work**

- F1. a) Were you exposed to noise at work during pregnancy? (not including guns/explosives)

Yes

☐

No

☐

→ **If no, go to F2a on page 44**

**If yes,**

- b) Describe what noisy job you had during pregnancy: .....

- c) About how many months pregnant were you when you stopped work? ☐ months

- d) List the different noisy tasks you were doing (or were going on really close to you) in your work, starting with the noisiest:

Task 1) .....

Task 2) .....

Task 3) .....



### **For Task 1**

- e) Approximately how many hours per week at work did you spend on Task 1?

--	--

 hours

- f) What was the source of noise? .....

- g) When trying to talk to another worker (who was also used to the conditions), without wearing hearing protection what sort of voice did you have to use:

When they were:	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
i) 4 feet away from you	1	2	3	4	5
ii) 2 feet away from you	1	2	3	4	5
iii) Close to your ear	1	2	3	4	5

- h) After performing Task 1, did you notice any of the following effects on your hearing, and if so, were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	1	2	3
ii) Tinnitus (noises in the ear or head)	1	2	3

- j) Did you wear hearing protection during Task 1?

Yes 

1
---

      No 

2
---

 → If **no**, go to F1m on page 42

If **yes**,

- k) What type of hearing protection did you wear? .....

- l) Approximately how many hours per week performing Task 1 did you wear hearing protection?

--	--

 hours

## **For Task 2**

F1. m) Approximately how many hours per week at work did you spend on Task 2?

--	--

hours

n) What was the source of noise? .....

o) When trying to talk in this working environment to another worker (who was also used to the conditions), what sort of voice did you have to use:

	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
<b>When they were:</b>					
i) 4 feet away from you	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii) 2 feet away from you	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii) Close to your ear	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

p) After performing Task 2, did you notice any of the following effects on your hearing, and if so, were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<div>1</div>	<div>2</div>	<div>3</div>
ii) Tinnitus (noises in the ear or head)	<div>1</div>	<div>2</div>	<div>3</div>

q) Did you wear hearing protection during Task 2?

Yes 

1
---

 No 

2
---

 → If **no**, go to F1t on page 43

If **yes**,

r) What type of hearing protection did you wear? .....

s) Approximately how many hours per week performing Task 2 did you wear hearing protection?

--	--

hours

**For Task 3**

F1. t) Approximately how many hours per week at work did you spend on Task 3?

--	--

 hours

u) What was the source of noise? .....

v) When trying to talk in this working environment to another worker (who was also used to the conditions), what sort of voice did you have to use:

	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
<b>When they were:</b>					
i) 4 feet away from you	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii) 2 feet away from you	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii) Close to your ear	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

w) After performing Task 3, did you notice any of the following effects on your hearing, and if so, were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<div>1</div>	<div>2</div>	<div>3</div>
ii) Tinnitus (noises in the ear or head)	<div>1</div>	<div>2</div>	<div>3</div>

x) Did you wear hearing protection during task 3?

Yes 

1
---

No 

2
---

 → If **no**, go to F2a on page 44

**If yes,**

y) What type of hearing protection did you wear? .....

z) Approximately how many hours per week performing Task 3 did you wear hearing protection?

--	--

 hours

## Social noise exposure during pregnancy

F2. a) Did you attend pop/rock concerts with live amplified music during pregnancy?

Yes  No  → If **no**, go to F3a below

If **yes**,

b) About how many times during pregnancy?   times

c) Roughly how many hours did you spend at each concert?   hours

d) If you were with another person at a concert, how loud did you have to talk to understand each other:

When they were:	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
i) 4 feet away from you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
ii) 2 feet away from you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
iii) Close to your ear	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>

e) Did you notice any of the following effects on your hearing after attending concerts, and if so, were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
ii) Tinnitus (noises in the ear or head)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

F3. a) Did you attend nightclubs or discos with music amplified through speakers during pregnancy?

Yes  No  → If **no**, go to F4a on page 45

If yes,

- F3. b) For approximately how many hours per day?   hours/ day
- c) For approximately how many days per week?  days/week
- d) About how many months pregnant were you when you stopped doing this?  months
- e) To talk with another person at a nightclub (at the place in the nightclub where you spend most of the time), how loud did you have to talk to understand each other:

When they were:	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
i) 4 feet away from you	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
ii) 2 feet away from you	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
iii) Close to your ear	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5

- f) Did you notice any of the following effects on your hearing after attending nightclubs, and if so, were they temporary or permanent?

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3
ii) Tinnitus (noises in the ear or head)	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3

- F4. a) During pregnancy, did you listen to music using earphones with a personal music system or hi-fi?

Yes  1

No  2

→ If no, go to F5a on page 46

If yes, when you did so:

- F4. b) For approximately how many hours per day?   hours/day
- c) For approximately how many days per week?  days/week
- d) When with another person while you were listening to music using earphones, with the volume at your normal level, how loud did they have to talk for you to understand them:

When they were:	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
i) 4 feet away from you	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
ii) 2 feet away from you	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
iii) Close to your ear	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5

- e) Did you notice any of the following effects on your hearing after listening to music using earphones, and were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3
ii) Tinnitus (noises in the ear or head)	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3

- F5. a) During pregnancy, did you listen to the TV or computer games using earphones?

Yes  1 No  2 → If no, go to F6a on page 47

If yes,

- b) For approximately how many hours per day?   hours/day
- c) For approximately how many days per week?  days/week

- F5. d) On average, to communicate with another person while you were listening to the TV/computer games using earphones, with the volume at your normal listening level, how loud did they have to talk for you to understand them:

When they were:	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
i) 4 feet away from you	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
ii) 2 feet away from you	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
iii) Close to your ear	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

- e) Did you notice any of the following effects on your hearing after listening to the TV/computer games using earphones, and were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
ii) Tinnitus (noises in the ear or head)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>

- F6. a) During pregnancy, did you listen to music through speakers (in your home or elsewhere)?

Yes  1      No  2 → If no, go to F7a on page 48

If yes,

b) Approximately how many hours per day?	<input type="text"/>	<input type="text"/>	hours/day
c) Approximately how many days per week?	<input type="text"/>		days/week

- F6. d) On average, to communicate with another person while you were listening to music through speakers, with the volume at your normal listening level, how loud did you have to talk to understand each other:

When they were:	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
i) 4 feet away from you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
ii) 2 feet away from you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
iii) Close to your ear	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>

- e) Did you notice any of the following effects on your hearing after listening to music through speakers, and were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
ii) Tinnitus (noises in the ear or head)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

- F7. a) During pregnancy, did you listen to in-car music?

Yes  No  → If **no**, go to F8a on page 49

If **yes**,

- b) For approximately how many hours per day?   hours/day
- c) For approximately how many days per week?  days/week



F7. d) On average, to communicate with another person in the car, with the volume at your normal listening level, how loud did you have to talk to understand each other:

When they were:	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
i) 4 feet away from you	1	2	3	4	5
ii) 2 feet away from you	1	2	3	4	5
iii) Close to your ear	1	2	3	4	5

e) Did you notice any of the following effects on your hearing after listening music in the car, and were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	1	2	3
ii) Tinnitus (noises in the ear or head)	1	2	3

F8. a) During pregnancy did you carry out DIY using power tools?

Yes  No  → If **no**, go to F9a on page 50

If **yes**,

b) For approximately how many hours in total?   hours

c) About how many months pregnant were you when you did it for the last time?  months

F8. d) On average, to communicate with another person whilst using power tools, how loud did you have to talk to understand each other:

When they were:	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
i) 4 feet away from you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
ii) 2 feet away from you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
iii) Close to your ear	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>

e) Did you notice any of the following effects on your hearing after using power tools, and were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
ii) Tinnitus (noises in the ear or head)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

F9. a) During pregnancy, did you ride a motor cycle?

Yes  No  → If no, go to F10a on page 51

If yes,

b) About how many hours per day?   hours/day

c) For approximately how many days per week?  days/week

d) How many months pregnant were you when you did this for the last time?  months

e) Did you notice any of the following effects on your hearing after riding a motor cycle, and were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
ii) Tinnitus (noises in the ear or head)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

F10. a) During pregnancy, apart from guns and explosions, were you exposed to any other loud noise?

Yes

No

→ If **no**, go to F11a below

If **yes**,

b) Please give details .....

c) For approximately how many hours per day?   hours/day

d) For approximately how many days per week?  days/week

e) On average, to communicate with another person how loud did you have to talk to understand each other:

	Normal voice	Raised voice	Very loud voice	Shout	Impossible to communicate
<b>When they were:</b>					
i) 4 feet away from you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
ii) 2 feet away from you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
iii) Close to your ear	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>

f) Did you notice any of the following effects on your hearing and were they temporary or permanent:

	Yes temporary	Yes permanent	No
i) Dullness of hearing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
ii) Tinnitus (noises in the ear or head)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

### Gun shots during pregnancy

F11. a) Did you fire guns during pregnancy?

Yes

No

→ If **no**, go to F12 on page 54

F11. b) Name the make and model of each gun you fired:

1. ....
2. ....
3. ....

**For Gun 1**

F11. c) Approximately how many rounds did you fire during pregnancy?

--	--	--

d) Did you wear hearing protection?

Yes 

1
---

 No 

2
---

 → If **no**, go to F11g below

If **yes**,

e) Which type of hearing protection did you use? .....

f) How many rounds did you fire wearing hearing protection?

--	--	--

g) How many rounds did you fire without wearing hearing protection?

--	--	--

h) Did you notice any immediate effect on your hearing after firing?

Yes 

1
---

 No 

2
---

 → If **no**, go to F11 part l) at the top of page 53

If **yes**,

i) Which ear?

Left 

1
---

 Right 

2
---

 Both 

3
---

j) What was the effect?

Slight 

1
---

 Moderate 

2
---

 Severe 

3
---

k) Was it a temporary or permanent effect?

Temporary 

1
---

 Permanent 

2
---

**For Gun 2**

F11. l) Approximately how many rounds did you fire during pregnancy?

m) Did you wear hearing protection?

Yes <sub>1</sub>

No <sub>2</sub>

→ If **no**, go to F11p below

If **yes**,

n) Which type of hearing protection did you use? .....

o) How many rounds did you fire wearing hearing protection?

p) How many rounds did you fire without wearing hearing protection?

q) Did you notice any immediate effect on your hearing after firing?

Yes <sub>1</sub>

No <sub>2</sub>

→ If **no**, go to F11u below

If **yes**,

r) Which ear?

Left <sub>1</sub>

Right <sub>2</sub>

Both <sub>3</sub>

s) What was the effect?

Slight <sub>1</sub>

Moderate <sub>2</sub>

Severe <sub>3</sub>

t) Was it a temporary or permanent effect?

Temporary <sub>1</sub>

Permanent <sub>2</sub>

**For Gun 3**

u) Approximately how many rounds did you fire during pregnancy?

v) Did you wear hearing protection?

Yes <sub>1</sub>

No <sub>2</sub>

→ If **no**, go to F11y on page 54

If yes,

F11. w) Which type of hearing protection did you use? .....

x) How many rounds did you fire wearing hearing protection?

--	--	--

y) How many rounds did you fire without wearing hearing protection?

--	--	--

z) Did you notice any immediate effect on your hearing after firing?

Yes

1
---

No

2
---

→ If no, go to F12 below

If yes,

za) Which ear?

Left

1
---

Right

2
---

Both

3
---

zb) What was the effect?

Slight

1
---

Moderate

2
---

Severe

3
---

zc) Was it a temporary or permanent effect?

Temporary

1
---

Permanent

2
---

## Explosions

F12. a) Were you exposed to any explosions during pregnancy?

Yes

1
---

No

2
---

→ If no, go to Section G  
on page 56

If yes,

b) How many explosions

--	--

c) Describe the type of explosion .....

d) Did you wear hearing protection?

Yes

1
---

No

2
---

F12. e) Did you notice any of the following after any of the explosions?

	<b>Yes temporary</b>	<b>Yes permanent</b>	<b>No</b>
i) Dullness of hearing	<div>1</div>	<div>2</div>	<div>3</div>
ii) Tinnitus (noises in the ear or head)	<div>1</div>	<div>2</div>	<div>3</div>

**SECTION G:**

G1. This questionnaire was completed by: (Please tick all that apply)

- Yes**
- a) child's biological mother ☐ 1
- b) child's mother figure ☐ 1
- c) someone else ☐ 1 .....
- (please describe)

G2. Do you live in the same house as the study child?

Yes ☐ 1 No ☐ 2

G3. Please give the date on which you completed this questionnaire:

day month year

☐ ☐ ☐ ☐ 2 0 0 ☐

G4. Please give your date of birth:

day month year

☐ ☐ ☐ ☐ 19 ☐ ☐

G5. Please give your study child's date of birth:

day month year

☐ ☐ ☐ ☐ 199 ☐

**THANK YOU VERY MUCH FOR YOUR HELP**

Space for any additional comments you would like to make.

**N.B. Please remember we cannot reply to any comment unless you sign it.**

When completed, please return the questionnaire to:

**Professor Jean Golding**  
**Children of the Nineties – ALSPAC**  
**Institute of Child Health**  
**24 Tyndall Avenue**  
**Bristol, BS8 1BR Tel: Bristol 9285007**

For office use only:

coder ☐ ☐ Int ☐ ☐

© University of Bristol